NOTIFICATION TO DMH
REGARDING PROVISION OF THERAPEUTIC BEHAVIORAL SERVICES

Identifying Data

Child/Youth's Name:
Social Security Number: or
Beneficiary Identification Number:
Beginning Date of Therapeutic Behavioral Services:
County/MHP Code or Name: San Bernardino County Dept. of Behavioral Health
Date:

Form completed by:
Michael Beavers, LMFT, TBS Coordinator
Phone: (909) 421-9399
Email: mbeavers@dbh.sbcounty.gov

Primary Residences for Child/Youth While Receiving TBS (Check all that apply)

- ☐ Family Home
- ☐ Foster Home
- ☐ Foster Family Agency
- ☐ Children's Shelter
- ☐ Group Home (specify RCL) Choose one
- ☐ Other (Specify):

Class Membership (Check One)

- ☐ In RCL 12 or above
- ☐ Being considered for RCL 12 or above
- ☐ One psychiatric hospitalization in preceding 24 months
- ☐ Previously received TBS while a class member

Service Need (Check One)

- ☐ To prevent placement in a higher level of care
- ☐ To enable transition to a lower level of care

TBS Service Plan

Planned average hours of TBS per week:
Estimated number of weeks TBS to be provided:

☐ Initial Information OR ☐ Quarterly Update

SUMBIT THIS FORM within the first thirty days of service and every quarter thereafter to:

Nancy Mengebier
Department of Mental Health
1600 9th Street, Room 100
Sacramento, CA 95814
Phone (916) 654-3486 Fax (916) 653-9194